MedStar Georgetown University Hospital

MedStar Georgetown University Headache Center
Department of Neurology * 7th floor PHC Bldg
3800 Reservoir Rd., NW, Washington, DC 20007-2113
202-444-8525

MEDICAL HISTORY

Please complete the following information:
Patient name: ________________________________ D.O.B.________________ Date: _______________

*The following information is very important to us in taking care of your health. Please take the time to fill out all of the information below. Update us with any changes.

Current Complaint

Please briefly describe the reason for your visit to our office today: ____
____
____
____

Past Medical History

Do you have any allergies to medications? ☐ Yes ☐ No
If yes, please list the medications and the associated allergic reaction:
____
____

List all medications you are currently taking (including over the counter):

Name	Dose?	Name	Dose?

Do you have any medical problems? ☐ Yes ☐ No
If yes, please explain:____
____
____

Have you ever been hospitalized? ☐ Yes ☐ No
If yes, please indicate: **Date/Hospital/City, State/Reason**
____
____

Have you had any surgeries? ☐ Yes ☐ No
If yes, please indicate: **Date/Hospital/City, State/Reason**
____
____

Social History

Who lives with you? ____
What are you doing for work? ____
Have you ever smoked? ☐ Yes ☐ No
Do you presently smoke? ☐ Yes ☐ No
If you smoke now, or did so previously, for how many years did you smoke? ______________________
If you have quit smoking, how long has it been since you stopped? ___________________________
If you smoke, indicate how much for each daily: Cigars:____ Pipes:____ Cigarettes: _____
Do you drink alcoholic beverages, and if so, what & how much? ☐ Yes ☐ No ______________________
Do you drink caffeinated beverages, if so, what & how much? ☐ Yes ☐ No ______________________
If you use recreational drugs, please notify your physician.
Do you exercise, if so, what and how often? ☐ Yes ☐ No _________________________________

Family Medical History

(i.e. stroke, diabetes, heart disease, headaches, cancer, Parkinson's disease, Alzheimer's disease, Multiple Sclerosis, seizures)
Mother: ___________________________ Brother/Sister: ___________________________
Father: ___________________________ Children: ___________________________
Grandparent: ____
Additional Information: ____

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HEADACHE HISTORY

DO YOU HAVE MORE THAN ONE HEADACHE TYPE? ☐ Yes ☐ No
If yes, please use an additional headache history sheet for each

ONSET OF FIRST HEADACHE:
Headaches started ___________ years ago.
I was: ☐ younger than 20 ☐ 20-30 ☐ 30-50 ☐ over 50 years old

PRECIPITATING EVENT (trigger of first headache):
☐ None Known ☐ Injury
☐ Menarche (first period) ☐ Pregnancy
☐ Other:_______________________________

FREQUENCY:
Headaches occur __________ times each ☐ Day ☐ Week ☐ Month
Are headaches increasing? ☐ Yes ☐ No
Headaches are more frequent:
☐ Weekdays ☐ Weekends ☐ Vacations
☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ No relation

ONSET:
Headache onset occurs: ☐ gradually ☐ suddenly ☐ varies
And most frequently in the: ☐ morning ☐ afternoon ☐ evening ☐ night

LOCATION:
Starts: ☐ left side of head ☐ right side of head ☐ either side of head ☐ both sides of head
☐ back of head ☐ neck ☐ behind eye(s) ☐ other: _____________________

DURATION:
Last ____ ☐ hours ☐ days WITHOUT medications
Last ____ ☐ hours ☐ days WITH medications

INTENSITY:
With medication: ☐ mild ☐ moderate ☐ severe ☐ incapacitating
Without medication: ☐ mild ☐ moderate ☐ severe ☐ incapacitating

DESCRIPTION OF PAIN TYPE:
☐ throbbing ☐ aching ☐ pressure ☐ stabbing ☐ shooting ☐ tight
☐ dull ☐ burning ☐ searing ☐ other: _____________________

HEADACHES EFFECT ON ABILITY TO FUNCTION:
☐ Able to function normally ☐ Ability to function slightly decreased
☐ Ability to function severely decreased ☐ Totally bedridden

HORMONAL:
Headaches are affected by: ☐ menstrual cycle ☐ pregnancy
How? ____

FREE OF HEADACHE from: _____________ to ______________ ☐ never free
If never free, when was the last time you went 24 hours without headache? ________________________________

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HEADACHES CAN BE BROUGHT ON BY:

☐ fatigue ☐ physical exertion ☐ stress ☐ weather changes ☐ hunger
☐ lack of sleep ☐ menstruation ☐ loud sounds ☐ high altitude ☐ alcohol
☐ too much sleep ☐ odors ☐ coughing ☐ bright lights ☐ medications
☐ chewing or talking ☐ sex/orgasm ☐ foods (which?____________________________)
☐ other: _____________________________

WARNINGS THAT A HEADACHE IS COMING:

☐ light flashes ☐ numbness ☐ upset stomach ☐ zigzag lines
☐ dizziness ☐ weakness ☐ blindness ☐ lightheadedness
☐ other: _____________________________

ASSOCIATED SYMPTOMS:

☐ nausea/vomiting ☐ one eye tears ☐ sore/stiff neck ☐ ringing in the ears ☐ odors
☐ numbness/tingling ☐ both eyes tear ☐ concentration ☐ lightheadedness ☐ dizziness
☐ increased urination ☐ constipation ☐ diarrhea ☐ fatigue ☐ weakness
☐ blurred/double vision ☐ increased appetite ☐ decreased appetite ☐ insomnia ☐ memory
☐ change in sexual interest ☐ anxiety, tension, or irritability ☐ other:
____

Sensitive to: ☐ lights ☐ sounds

DURING A HEADACHE, YOU ARE MORE COMFORTABLE:

☐ lying down ☐ with massage or pressure on scalp ☐ when pacing
☐ in a dark, quiet room ☐ with hot or cold compress ☐ chewing or talking
☐ other: _____________________________

PREVIOUS TESTING (please give date & results):

MRI: ____ Cervical spine films: ____
CT Scan: ____________________________________ Sinus x-rays: ____
EEG: ____ Angiogram: ____
Sleep study: ________________________________ Other: ____

PREVIOUS EVALUATIONS (please give name, date & results):

Neurologist: ____
Headache specialist: ____
Internist: ____
Ear, Nose, & Throat Specialist: ____
Dental eval: ____
Eye exam: ____
Psychological Testing: ____

PREVIOUS NON-MEDICAL TREATMENTS AND EVALUATIONS:

☐ biofeedback/relaxation/self hypnosis ☐ physical therapy ☐ chiropractor
☐ acupuncture/acupressure ☐ nutritional counseling ☐ allergy testing
☐ other: _____________________________

ARE YOU CURRENTLY TAKING MEDICATION FOR HEADACHE or HAVE YOU PREVIOUSLY TAKEN MEDICATION FOR HEADACHE? ☐ Yes ☐ No **If yes, please complete the medication history on the following page**

WITH CURRENT MEDICATION, HOW QUICKLY DO YOU FEEL ADEQUATE RELIEF?

☐ within 2 hours ☐ in more than 2 hours
☐ relief is never adequate ☐ not currently taking medication

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REVIEW OF SYSTEMS

Please place "X" in the appropriate column:

	In the past year	**Never**
General		
Weight loss (how much?)	______	______
Weight gain (how much?)	______	______
Fevers	______	______
Shaking chills	______	______
Trouble sleeping	______	______
Eyes		
Double vision	______	______
Cataracts	______	______
Blurred vision	______	______
Loss of vision	______	______
Ears, Nose, & Throat		
Ringing in ears	______	______
Hearing loss	______	______
Hoarseness	______	______
Cardiovascular		
Heart murmur or fainting	______	______
High blood pressure	______	______
Chest pain or tightness	______	______
Hear t attack	______	______
Palpitations	______	______
History of irregular pulse	______	______
Respiratory		
Chronic cough	______	______
Shortness of breath	______	______
Gastrointestinal		
Abdominal pain	______	______
Vomiting	______	______
Recent change in bowel habits	______	______
Bleeding	______	______
Genitourinary		
Pain when voiding	______	______
Frequent urination	______	______
Dribbling after urination	______	______
Blood in urine	______	______
Musculoskeletal		
Back pain	______	______
Arthritis (note in joints)	______	______
Neck pain	______	______

	In the past year	**Never**
Dermatological		
Rashes	______	______
Neurological		
Frequent headaches	______	______
Loss of speech/speech change	______	______
Tremor or shaking	______	______
Numbness in extremities	______	______
Numbness in face	______	______
Convulsions (seizures)	______	______
Stroke	______	______
Psychiatry		
Depression	______	______
Anxiety	______	______
Memory loss	______	______
Endocrine		
Cold intolerance	______	______
Heat intolerance	______	______

Age of onset of menses ____________
Last menstrual period ____________
If female, are you pregnant? ☐ Yes ☐ No
Are you planning to become pregnant? ☐ Yes ☐ No
(If you become pregnant, please inform your provider immediately)

Hematology		
Easy bruising	______	______
Bleeding	______	______
Allergy		
Hay fever	______	______
Allergic rash	______	______

To the best of my belief, the above information is true and accurate.

Signature: ____

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Circle medications taken in the past:

Prophylactics

Blocadren or Timolol
Corgard or Nadolol
Inderal or Propanolol
Lopressor/Metoprolol/Toprol
Tenormin or Atenolol
Bystolic
Cardizem/Diltiazem
Covera, Verelan, Calan, Verapamil
Norvasc
Procardia or Nifedipine
Catapress or Clonidine
Zestril
Prinivil or Lisinopril
Atacand
Neurontin/Gabapentin
Lyrica
Dilantin/Phenytek/Phenytoin
Tegretol, Carbatrol or Carbamazepine
Trileptal
Depakote/Valproic Acid
Topamax
Lamictal
Zonegran
Phenobarbital
Keppra
Elavil or Amitriptyline
Pamelor or Nortriptyline
Trazadone
Desipramine
Tofranil or Imipramine
Wellbutrin or Bupropion
Prozac or Fluoxetine
Zoloft or Sertraline
Paxil
Luvox
Celexa
Lexapro
Effexor
Cymbalta
Pristiq

Prophylactics (cont)

Savella
Eskalith, Lithobid or Lithium
Nardil
Parnate
Mexilitine
Methergine
Haldol
Zyprexa
Geodon
Seroquel
Risperdal
Abilify

Muscle Relaxants

Zanaflex or Tizanidine
Soma or Carisoprodol
Baclofen/Lioresal
Skelaxin or Metaxalone
Amrix
Flexeril/Cyclobenzaprine
Robaxin or Methocarbamol

Sleep aides/anxiety

Xanax or Alprazolam
Ativan or Lorazepam
Valium or Diazepam
Librium or Chlordiazepoxide
Klonopin or Clonazepam
Buspar or Buspirone
Sonata
Ambien
Rozerem
Lunesta

Procedures

Greater Occipital nerve block
Trigeminal nerve block
Botox
Amount injected? _______________

Anti-nausea

Benadryl or Diphenhydramine
Compazine or Prochlorperazine
Reglan or Metoclopromide
Phenergan or Promethazine
Thorazine or Chlorpromazine
Vistaril or HydroxyzineAbortives

Abortives

Midrin, Amidrin or Isomepthene
Imitrex/Treximet
Zomig
Amerge
Maxalt
Axert
Frova
Relpax
DHE-45
Migranal Nasal Spray
Ergostat
Ergotamine or Ergomar
Cafergot

Rescue Medication

Tylenol
Anacin or Excedrin
Motrin, Advil or Ibuprofen
Anaprox, Aleve, Naprelan, Naprosyn or Naproxen Sodium
Orudis, OruVail or Ketoprofen
Voltaren, Cataflam, Arthotec or Diclofenac
Toradol or Ketorolac
Lodine or Etodolac
Relafen or Nabumetone
Indocin or Indomethacin
Mobic or Meloxican
Ansaid or Flurbiprofen
Celebrex
Prednisone/Dexamethasone/Medrol pack/Depo-Medrol
Solumedrol/Decadron

Current medications: